Patient Identification Process in a Regional Network

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Our hospital has been working on the achievement of a regional CHIN. The approach chosen for patient identification has been to utilize a master identifier linked to each participating entity's unique patient indentifier. One of the requirements of the software chosen is for each participating entity to have only one unique identifier per patient. Through the process of making the hospital transfusion service paperless, it was recognized that some individuals had more than one unique identifier and that some records had been inappropriately merged.

Thorough investigation of such instances revealed several weaknesses in the process of patient identification, admissions, merging of records, etc. Via informal meetings with representatives of the laboratory, medical records, admissions, and hospital information systems, it was recognized that patient identification data integrity was most at risk due to the human element rather than inappropriate electronic processes. Furthermore, the scope of human interaction was far greater than originally anticipated.

A larger multi-disciplinary task force was formally created in the hospital to deal with these patient identification issues. The task force includes representation from medical records, admissions, laboratory, pharmacy, radiology, hospital information systems, finance, and quality improvement. In addition, parallel representation from other participating entities were invited to participate. One other institution has representatives from medical records, admissions, and information services. The goals of the group were to learn more about the processes, software, current databases status, and to formulate multi-institutional policy and procedures related to patient identification.

It was recognized early on in the process that there was no one department in the hospital which had authority and responsibility over the management of patient electronic records. Since the institution does not have a medical information office, the recommendation was to make the group a subcommittee of the medical record committee. Another recommendation included revision of admission procedures to insure correct utilization of current admission software. The hospital information system downtime procedure was reviewed and revised. In addition, policy was established as to database "clean-up" prior to "back-loading" into the current regional network patient identification database.

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